benefit promised under the plan and has no further liability under the plan.[6]

Thus it is that a medical plan may be described as "insured" without establishing whether the employer bears ultimate financial responsibility for the reimbursements. If the employer has promised the bottom-line result – reimbursement of medical expenses – then the employer bears ultimate financial responsibility regardless of whether there is any insurance or trust. But if the employer has promised only to pay premiums on insurance, the employer has not promised reimbursement of expenses and thus bears no responsibility under the plan for reimbursing employees for covered medical expenses.

Not only is this latter approach permissible under ERISA, but it is vital in the interest of certain businesses, especially small business. Most small businesses cannot afford to promise reimbursement of expenses, because just one significant expense, such as open heart surgery or a premature birth, can wipe out the employer. Small businesses do not have the luxury of a large population of employees over which to spread the risk. In order to be able to provide any medical benefits at all, small businesses must be able to insure and thereby cap their exposure at the premiums paid.

---

[6] As noted in the petition, the plan at issue in this case is of this latter type, where the employer's liability is expressly limited to payment of premiums. Pet. at 4.

B. Medicare Secondary Payer Imposes Liability On Only Those Employers Who Bear Ultimate Financial Responsibility For the Benefits Under Their Plans, Whether Insured or Not.

In the decision below, the Federal Circuit struggled with a question that it saw as "black or white": are all employers with insured plans exempt from Medicare Secondary Payer or are all employers with insured plans automatically subject to Medicare Secondary Payer?

Once it is understood that some employers with insured plans bear ultimate financial responsibility for reimbursement of medical expenses but others do not, a middle ground appears: Medicare Secondary Payer applies to those employers with insured plans who bear ultimate financial responsibility for reimbursement of medical expenses under their plans but does not apply to those employers who have chosen to limit their promise to the payment of premiums and therefore bear no responsibility for reimbursement of medical expenses under their plans. This middle ground harmonizes all of the words of the statute, preserves its core value, and avoids burdening employers in conflict with ERISA.

The statute permits the United States to recover from "any or all entities that are or were *required or responsible . . . to make payment* with respect to the same item or service . . . *under a primary plan*." 42 U.S.C. § 1395y(b)(2)(B)(iii) (emphasis added). Because of disagreements over the years as to who those entities might be, Congress added and then beefed up a parenthetical giving examples of entities that might be "required or responsible . . . to make payment . . . under a primary plan." That parenthetical list includes "self-insurer[s]" and also "an employer that sponsors or contributes to a group health plan." *Ibid.*

The essence of the problem confronting the Federal Circuit was that neither of the "black or white" extremes fit the statute as written:

– The view that Medicare Secondary Payer applies to self-insured employers but not to those which insure their plans is contradicted by the parenthetical list, which mentions both employers that self-insure and others who do not. Congress clearly knew that some employers self-insure, while others purchase insurance, and did not intend to exempt the latter categorically.

– The contrary interpretation (that Medicare Secondary Payer applies to all employers whether or not they insure their plans) is contradicted by the language that flanks the parenthetical. That is, the statute provides that Medicare Secondary Payer applies to entities such as those in the parenthetical who are "responsible . . . to make payment with respect to the same item or service . . . under a primary plan," but there are many employers with insured plans who are not responsible to make payment under their plans, so it cannot be said that Medicare Secondary Payer applies to all employers whether or not they insure their plans. (Such an interpretation could not be maintained without reading "that are . . . responsible . . . to make payment . . . under a primary plan" out of the statute.)[7]

---

[7] In the past, respondents have relied on two district court cases (App. at 48a), but they do not stand for the proposition for which they are cited. In *Provident Life and Accident Ins. Co. v. United States*, 740 F. Supp. 492 (E.D. Tenn.1990), the court declared that the employer would bear ultimate financial responsibility if, hypothetically speaking, the plan were self-funded. In *United States v. Blue Cross and Blue Shield of Michigan*, 726 F. Supp. 1517 (E.D. Mich.1989), the court

(Continued on following page)

The middle ground harmonizes all of the words of the statute. The middle ground is that Medicare Secondary Payer applies to those employers, including those who purchase insurance, who bear ultimate responsibility for reimbursement of medical expenses under their plans but does not apply to those employers who have chosen to limit their liability to payment of premiums and therefore do not bear any responsibility for reimbursement of medical expenses under their plans. That is exactly what the statute says. Medicare Secondary Payer applies to "any and all entities that are required or responsible . . . to make payment . . . under a primary plan," including, for example, those who may be responsible "as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan."

Thus, an insured employer that nevertheless has chosen to promise the ultimate benefit of reimbursement of medical expenses under its plan can be liable under Medicare Secondary Payer. But an insured employer that has chosen to limit its liability to the purchase of insurance and thus does not bear any responsibility for reimbursement of medical expenses is not liable under Medicare Secondary Payer. All of the words of the statute are given meaning, all are given their normal meanings, and none are surplusage. In addition, that reading preserves the intent behind the statute and saves it from a fatal conflict with ERISA.

---

stated that the employer bore full financial responsibility under the plan because, once again, the plan was self-funded. Neither of those cases said, even in *dicta*, that the employer always bears ultimate financial responsibility under an *insured* plan. (As shown above, that depends on the nature of the promise made by the employer in the plan document.)

As explained by the petitioner in the petition (at 2-4, 8-11), the intent behind the statute from its origin has been to assure that the entity that should have paid the expense in the first place pays it in the end. That is to say, Congress has always intended to fasten liability on the party who would have borne the cost if Medicare had not made the mistake of paying on a primary basis. Of course, that is the entity that bears ultimate financial responsibility for reimbursement of medical expenses under the terms of the plan.[8]

Nowhere in the statute or its legislative history has Congress breathed a single word about creating a *new* liability and fastening it on a party that *never was responsible* for the expenses in the first place under the terms of the plan. And yet that is the result of the decision below: employers that capped their exposure at the payment of premiums, as they are allowed to do under ERISA and must do for their own survival, now face open-ended liability for medical expenses, all depending on the vagaries of whether Medicare pays a claim by mistake and whom Medicare goes after for reimbursement.

Besides doing violence to the language of the Medicare Secondary Payer statute and the uniform intent of Congress, the decision below needlessly puts Medicare Secondary

---

[8] The exception proves the rule. The exception is that Medicare may collect from a third-party administrator, which by definition does not bear ultimate responsibility for reimbursements. 42 U.S.C. § 1395y(b)(2)(B)(iii). But the exception limits that right of recovery to those situations where the third-party administrator remains entitled to reimbursement from the entity that really does bear ultimate financial responsibility. *Ibid.* Thus, the exception proves the rule that Congress always intended the liability to end up with the entity that bears ultimate financial responsibility under the terms of the plan.

Payer in conflict with ERISA. That is to say, ERISA leaves employers free to cap their liability by promising to pay premiums on insurance policies, rather than promising to provide reimbursement of medical expenses. ERISA assures employers that they control the promise and will not be held to any liability that they have not voluntarily taken on in their plans. But the decision below conjures a liability out of thin air and imposes it on the employer contrary to the terms of the employer's plan and the assurance of ERISA. An interpretation of Medicare Secondary Payer that places it in plain conflict with ERISA should be strongly disfavored.

C. Imposing a New Liability at Random on Small Business Is Exactly the Wrong Policy to Encourage Expansion of Health Insurance Coverage.

The effect of the decision below is to say to small business, "You may have thought that you were fully insured for medical expenses, so that your cost was fixed at the insurance premium. But if Medicare makes a mistake in paying a claim and chooses to come after you, you are not insured after all. Instead, you owe Medicare for the full amount of the claim. You never know when this might happen and there's nothing you can do about it."

One of the fundamental purposes of ERISA was to promote and encourage the formation of employee benefit plans. This Court has been vigilant in pursuit of that purpose, striking down decisions of lower courts that, however well intended, threatened to burden the maintenance of employee benefit plans in ways not contemplated by Congress and, ironically, lead to the elimination of employee benefit plans. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990), *Curtiss-Wright v. Schoonejongen*, 514 U.S.

73 (1995), *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996), *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999). The decision below is such a decision.

It is bad enough that the decision below strips from small business the critical protection of insurance against medical expenses that ERISA affords to them. The more frightening aspect is that the liability is entirely unpredictable and capricious. The liability is unpredictable because there is no way of knowing in advance what claims Medicare will pay by mistake, nor whether those expenses will be large or small. The liability is capricious because Medicare at its whim may compel reimbursement from the plan, the insurance company or (according to the decision below) the employer. Any court should hesitate to interpret a statute in such a manner as to give the government, at its whim, the ability to impose liability on the employer for a mistake that the government made. How can small business reasonably be expected to guarantee the accuracy of Medicare's claims processing?

The current climate is one in which small business struggles to provide any health insurance at all. While small business is widely recognized as the engine of the U. S. economy, the percentage of small businesses that provide health insurance has actually been declining in recent years, according to authoritative studies, and the principal reason has been cost.[9] The decision below, which

[9] "While the percentage of firms offering health benefits is statistically unchanged from last year, it has declined over the last few years. Annual changes have been small, but the cumulative result is a statistically significant decline in the percentage of firms offering health benefits, from 69% in 2000 to 60% in 2005. This drop is driven largely by a significant decline in the percentage of small firms (3-199 workers) offering coverage, which has fallen from 68% to 59% over the

(Continued on following page)

imposes a new, unpredictable liability at random on those small businesses that provide health insurance, can only accelerate the trend toward loss of coverage, contrary to the desire of Congress.

D. Given the Exclusive Jurisdiction of the Federal Circuit, It Would Be Futile to Await a Conflict Among the Circuits.

Speaking for the business community, especially the small business community, we wish to underline the urgency of this case and the futility of awaiting a conflict among the circuits. As noted in the petition (Pet. at 17-18), respondents have a suitable means of vindicating their illegitimate claims for reimbursement without ever bringing an action in federal court which might expose them to the threat of an inconsistent decision. That is, respondents can and do rely on the Treasury Offset Program, which permits them to take the amount of their claim out of the employer's tax refund.

And if an employer should be motivated to sue for a refund, as petitioner did in this case, the Federal Circuit would have exclusive jurisdiction of the appeal, guaranteeing the same outcome.

In short, no further development of the issue can be expected. This Court's review of this case is the only hope that small business has of correcting this error and avoiding

---

same period." The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2005 Summary of Findings" at 4 (2005). Cost is overwhelmingly cited as the reason. *Id.* at chart #11.

its inevitably debilitating effect on the willingness of small business to offer medical insurance.

CONCLUSION

In ERISA, Congress sought and achieved a balance between the rights of employees (and others) and the burdens on employers, recognizing that misguided regulation could easily go overboard and, ironically, lead to the elimination of employee benefit plans. This Court has repeatedly upheld the balance that Congress achieved in ERISA against those who would upset it by imposing additional burdens on employers, and the time has come to do so again by granting *certiorari* in this case – a case that threatens the backbone of the private system of medical insurance, namely, small business.

Respectfully submitted,

Of Counsel:
STEPHEN A. BOKAT
ROBIN S. CONRAD
ROBERT J. COSTAGLIOLA
NATIONAL CHAMBER
LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, DC 20062
(202) 463-5337

HOLLIS T. HURD
Counsel of Record
THE BENEFITS DEPARTMENT
Suite 120
3 Penn Center West
Pittsburgh, PA 15276
(412) 788-2334

Counsel for Amici Curiae

4

FILED
DEC 12 2005
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 05-263

IN THE
Supreme Court of the United States

TELECARE CORP.,
Petitioner,

v.

MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and CENTER FOR MEDICARE AND MEDICAID SERVICES,
Respondents.

On Petition for Writ of Certiorari
to the Court of Appeals for the Federal Circuit

REPLY BRIEF FOR PETITIONER

JAMES WALSH
BRUCE LAMKA
EDWIN D. RAUZI
JEFFREY L. FISHER*
DAVIS WRIGHT TREMAINE LLP
2600 Century Square
1501 Fourth Avenue
Seattle, WA 98101-1688
(206) 622-3150

*Counsel of Record

TABLE OF CONTENTS

REPLY BRIEF FOR PETITIONER 1

A. The 2003 Amendments To The MSP Statute Do Not Impose Non-contractual Liability On Employers. 2

B. This Court Should Review This Issue Without Delay. 6

CONCLUSION 8

TABLE OF AUTHORITIES

Cases:

Central Laborers' Pension Fund v. Heinz, 541 U.S. 739 (2004) 3

Curtiss-Wright v. Schoonejongen, 514 U.S. 73 (1995) 3

Health Insurance Ass'n v. Shalala, 23 F.3d 412 (D.C. Cir. 1994) 1, 4

Statutes and Regulations:

42 U.S.C. § 1395y(b)(1)(A)(ii) 5

42 U.S.C. § 1395y(b)(2)(A) 2

42 U.S.C. § 1395y(b)(2)(b)(iii) ..... passim

42 U.S.C. § 1395y(b)(3)(A) 7

42 C.F.R. § 411.24(e) 2

Other authority:

Routh, Paul J., Benefits Guide: Health Plans and Other Employer Sponsored Benefits § 3:22 (Nov. 2005 database update) 5

REPLY BRIEF FOR PETITIONER

The government does not dispute that, prior to the Federal Circuit's decision in this case, federal courts of appeals uniformly agreed that the government could invoke the MSP statute only against employers that were *contractually obligated* to pay for an individual's medical services. *See* Pet. for Cert. at 8-10 (citing cases from several federal circuits); Br. of Chamber of Commerce et al. as *Amici Curiae* (hereafter "Business *Amici*") at 13. Yet the government contends that the 2003 amendments to the MSP statute – which it acknowledges were enacted "to clarify rather than to change the law" (BIO at 5) – nevertheless effectuated a fundamental and profound change in Medicare law, creating a brand new system under which the government may require employers to pay for their employees' medical care even when employers bear no contractual financial responsibility whatsoever for those services. Under the government's view, Congress – without ever breathing a single word in a single hearing or report on the matter – intended in 2003 to transform a mere administrative "reimbursement" mechanism into a new system of liability that contravenes not just the prior conception of the MSP program but also, as the Business *Amici* explain, basic principles of ERISA law.

The government's argument – to borrow the D.C. Circuit's phrase from the only other time in which the government has advanced a similar position – is "a complete jumble." *Health Ins. Ass'n v. Shalala,* 23 F.3d 412, 417 (D.C. Cir. 1994). It cannot be that the 2003 amendments simultaneously did nothing at all and also transformed the MSP system fundamentally. Rather, the amendments can and should be treated as leaving in place the principle that the government may recover money from employers under the MSP statute only when those employers had a contractual obligation in the first instance to pay for a medical item or service. The Federal

Circuit's transformative decision to the contrary should be reviewed at once.

A. The 2003 Amendments To The MSP Statute Do Not Impose Non-contractual Liability On Employers.

The government asserts that any employer that sponsors or contributes to a group health plan is subject to the government's MSP recoupment power, "without regard to whether the [employer] was contractually . . . required to pay for the cost of medical care." BIO at 8.[1] This argument for extending the government's power beyond situations involving pre-existing contractual liability suffers from three major deficiencies.

1. The government is unable to give meaning to the MSP reimbursement statute's operative terms. An entity is subject to the government's MSP recoupment power only if it is "responsible . . . under a primary plan" for paying for the medical care at issue. 42 U.S.C. § 1395y(b)(2)(B)(iii). Yet the government never seriously engages with this language. The most it does is quickly assert at one point that, because employer plan contributions may lose their tax deductible status if third-party insurers illegally discriminate against Medicare recipients, employers that establish third-party insurance arrangements are "*responsible* for payment being made in a manner that comports with the requirements of the MSP statute." BIO at 3, 8 (emphasis added).

---

[1] The government also suggests (BIO at 8) that a regulation that existed prior to the 2003 amendments, 42 C.F.R. § 411.24(e), interpreted the MSP statute this way. But the key language in the government's brief appears nowhere in that regulation. Nor had any court ever interpreted the regulation to mean what the government says here it meant. That is because the regulation simply said the same thing as the statute itself.

Not even the Federal Circuit accepted this argument for satisfying § 1395y(b)(2)(B)(iii)'s responsibility requirement, for it ignores that an entity is subject to the government's MSP recoupment power only if it is "responsible" – to repeat – "*under a primary plan*" for paying for the medical service at issue. 42 U.S.C. § 1395y(b)(2)(B)(iii) (emphasis added).[2] Employers such as Petitioner have no such responsibility *under a primary plan*. Indeed, the very purpose of third-party insurance arrangements is to create primary plans under which insurance companies bear sole responsibility for paying employees' medical bills. And such arrangements do not somehow "shift" financial responsibility to insurance companies or "relieve" employers of some responsibility to reimburse Medicare when Medicare pays for their employees' medical services. BIO at 8, 10. Employers do not have any responsibility in the first place to offer any medical plans to employees. *See, e.g., Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743 (2004) ("Nothing in ERISA requires employers to establish employee benefit plans."); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995) (same). Nor do employers have any pre-existing or default obligation to pay for employees' medical services that are covered by Medicare. Such an obligation arises only when an employer voluntarily decides to "bear[] the ultimate responsibility for satisfying those expenses." Business *Amici* Br. at 7.

---

[2] Of course, the Federal Circuit tried to finesse the "responsibility" requirement in the MSP statutory language in a different way, asserting that the term "responsible" means "involving a degree of accountability." Pet. App. 16a. But, as Petitioner and the Business *Amici* have explained, this suggestion, even if true, does not support the Federal Circuit's holding. Employers who simply pay premiums to insurance companies have no degree of accountability whatsoever for their employees' medical bills. Pet. for Cert. at 11; Br. of Business *Amici* at 3 n.2. That is presumably why the government advances a different argument here instead of trying to defend the Federal Circuit's analysis on this point.

In short, the MSP statute's antidiscrimination provisions simply encourage employers to ensure that third-party insurers pay for employees' medical coverage on an equal basis. They do not impose any obligation on *non-insurers* actually to pay medical bills. *See Health Ins. Ass'n,* 23 F.3d at 427 (Henderson, J., concurring).

2. The government's suggestion that its position is necessary to give meaning to other statutory terms likewise fails to withstand scrutiny. The government posits that the Federal Circuit's transformation of the MSP program is necessary to give independent meaning to the statute's parenthetical indication that it reaches "an employer that sponsors or contributes to a group health plan." BIO at 9 (quoting § 1395y(b)(2)(B)(iii)). But the government's assertion (BIO at 9) that this quoted phrase would not be necessary to cover self-insuring governmental, non-profit or charitable employers simply does not follow from the statute's restrictive definition of self-insuring entities, which is limited to entities engaged in a "business, trade, or profession." 42 U.S.C. § 1395y(b)(2)(A).

Perhaps more important, the government does not even try to refute the Business *Amici*'s explanation that the quoted phrase also can be read independently to apply to all kinds of employers that purchase third-party insurance but "still bear ultimate financial responsibility for the benefits." Br. of Business *Amici* at 3-4. Given the ready availability of interpretations that give meaning to the quoted phrase and that are consistent with the longstanding conception of the MSP program – a conception the government itself acknowledges was not supposed to be altered in the 2003 amendments (BIO at 5) – the Federal Circuit should have adopted one.

3. The government's construction of the statute also is at loggerheads with its overriding purpose. Petitioner and the Business *Amici* have explained that imposing the new kind of

non-contractual MSP liability the Federal Circuit has created would push small employers to cease offering any medical plans to employees. Such repeals of coverage would shift those expenses – contrary to the cost-cutting purpose of the MSP program – solely to Medicare. Pet. for Cert. at 2, 16; Business *Amici* at 15-16. The government responds that this is immaterial because "small employers are exempt from the statute's requirements." BIO at 9. Yet the statute exempts only those businesses with fewer than twenty employees. 42 U.S.C. § 1395y(b)(1)(A)(ii). The legion of small businesses with twenty or more employees would face exactly the perverse choice Petitioner has described.

The government also insists that employers that sponsor or contribute to health plans can protect themselves from liability either by persuading their insurance carriers always to reimburse Medicare directly (even if outside of the customary one-year period for submitting claims) or by negotiating indemnity provisions. BIO at 10. "Although this advice . . . may sound good, as a practical matter, most carriers simply will not amend their contracts" to cover claims outside of standard contractual limitations periods. Paul J. Routh, Welfare Benefits Guide: Health Plans and Other Employer Sponsored Benefits § 3:22 (Nov. 2005 database update) (commenting on Federal Circuit's decision here). And it blinks reality to suggest that small or even big businesses will be able to extract indemnity provisions from third-party insurers. The government does not provide any evidence that any employer has ever done so, and Petitioner is not aware of any either.

B. This Court Should Review This Issue Without Delay.

The government does not dispute the importance of the question presented, but it urges this Court to delay review for two reasons. Neither withstands scrutiny.

1. The government states that the Federal Circuit's decision is the first appellate decision to interpret the 2003 amendments and suggests that it does not conflict with the decisions Petitioner cites (Pet. for Cert. at 9-10) because those decisions "were decided before Congress enacted the 2003 amendments." BIO at 10. Yet, as the government acknowledges elsewhere, "Congress formally declared that the amendments were 'clarifying,' 117 Stat. 2221," and were not "intended . . . to change the law." BIO at 5. Accordingly, the fact that the Federal Circuit's decision disagrees with prior uniform precedent to hold that the MSP statute goes beyond contractual obligations to create new liability is highly relevant, deeply troubling, and worthy of prompt review.

2. Although the government does not dispute that any future case an employer brings respecting the question presented will flow to the Federal Circuit, it asserts that further percolation may still prove useful because future cases may arise in other circuits if (a) the government sues employers who are not subject to the treasury offset program or (b) private parties initiate private cases against other private parties. BIO at 11-12. Neither hypothetical scenario, however, supports the government's assertion.

First, the government does not point to a single actual case – either before or after the 2003 amendments – in which it has sued an employer under the MSP statute for the cost of an individual employee's medical bills. Nor is Petitioner aware of any. This is hardly surprising, since the treasury offset program is almost always available, and when it is not, the

government uses other heavy handed collection methods to get the money it wants. In its demand letters, the government tells employers that a failure to pay may result in the government disqualifying the employer's plan, thereby subjecting all the employer's contributions to taxation. The government also threatens to seek double damages from employers, as provided in 42 U.S.C. § 1395y(b)(2)(B)(iii). Pet. App. 49a. Thus, in order for an employer to oppose the government's position in a manner that would subject it to appellate litigation outside of the Federal Circuit, an employer would have to risk significant penalties that go well beyond the amount at issue. Apparently no employer ever has been willing to do so with respect to a dollar amount that the government thought was worth pursuing by filing suit.

Second, any private cause of action a party initiates will not squarely raise the question presented because it would involve a different statutory provision than is at issue here. The private action provision requires lawsuits to be brought when "a primary plan fails to pay," 42 U.S.C. § 1395y(b)(3)(A); it does not give private parties the power – as the government says it has in the statute at issue here – to sue an entity, other than a plan, that bears no contractual responsibility to pay for a medical service. BIO at 8. Even if the government were correct that employers that sponsor third-party insurance are somehow "responsible" under § 1395y(b)(2)(B)(iii) to pay for medical services, it would be a different matter to say that such employers are plans themselves, as would be required in the context of a private lawsuit.

Accordingly, this Court should use this case to review the question presented, as it is highly unlikely that another suitable vehicle will arise anytime soon, if at all.

CONCLUSION

For the foregoing reasons, as well as those stated in the petition for certiorari, the petition for writ of certiorari should be granted.

Respectfully submitted,

JAMES WALSH
BRUCE LAMKA
EDWIN D. RAUZI
JEFFREY L. FISHER*
DAVIS WRIGHT TREMAINE LLP
2600 Century Square
1501 Fourth Avenue
Seattle, WA 98101-1688
(206) 622-3150

December 2005

*Counsel of Record